

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0037960</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Columbus Park Nrsgr Rehab Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>901 South Austin</u> <u>Chicago</u> <u>60644</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(773) 287-5959</u> Fax # <u>(773) 287-7909</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
IDPA ID Number: <u>363801333001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>01/01/92</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr# 0037960 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsn/a

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>108</u>	Skilled (SNF)	<u>108</u>	<u>39,420</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>108</u>	Intermediate (ICF)	<u>108</u>	<u>39,420</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>216</u>	TOTALS	<u>216</u>	<u>78,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,998</u>	<u>445</u>	<u>3,790</u>	<u>19,233</u>	8
9	SNF/PED					9
10	ICF	<u>51,158</u>	<u>1,517</u>	<u>156</u>	<u>52,831</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>66,156</u>	<u>1,962</u>	<u>3,946</u>	<u>72,064</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 91.41%

D. How many bed-hold days during this year were paid by Public Aid?

1,705 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/92

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 01/01/92NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 19

and days of care provided

2,709Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Columbus Park Nrsgr Rehab Ctr # 0037960 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	233,510	52,428	35,832	321,770		321,770	(19,934)	301,836		1
2	Food Purchase		322,660		322,660	(29,565)	293,095	(88)	293,007		2
3	Housekeeping	167,784	38,224		206,008		206,008	642	206,650		3
4	Laundry	85,798	24,892		110,690		110,690		110,690		4
5	Heat and Other Utilities			188,414	188,414		188,414	2,374	190,788		5
6	Maintenance	41,177	25,801	156,341	223,319		223,319	(36,698)	186,621		6
7	Other (specify):*							10,409	10,409		7
8	TOTAL General Services	528,269	464,005	380,587	1,372,861	(29,565)	1,343,296	(43,295)	1,300,001		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	2,051,526	87,973	246,070	2,385,569		2,385,569	(29,346)	2,356,223		10
10a	Therapy	117,502	3,072	21,459	142,033		142,033	(2,631)	139,402		10a
11	Activities	97,857	8,967	3,557	110,381		110,381		110,381		11
12	Social Services	92,100		8,197	100,297		100,297		100,297		12
13	Nurse Aide Training										13
14	Program Transportation			240	240		240		240		14
15	Other (specify):*							5,593	5,593		15
16	TOTAL Health Care and Programs	2,358,985	100,012	286,723	2,745,720		2,745,720	(26,384)	2,719,336		16
	C. General Administration										
17	Administrative	110,860		539,127	649,987		649,987	(381,173)	268,814		17
18	Directors Fees										18
19	Professional Services			177,702	177,702	(5,150)	172,552	(122,376)	50,176		19
20	Dues, Fees, Subscriptions & Promotions			37,261	37,261		37,261	(15,696)	21,565		20
21	Clerical & General Office Expenses	92,430	29,578	108,932	230,940		230,940	(10,282)	220,658		21
22	Employee Benefits & Payroll Taxes			485,344	485,344	29,565	514,909	(319)	514,590		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,402	4,402		4,402	32	4,434		24
25	Other Admin. Staff Transportation			308	308		308	3,126	3,434		25
26	Insurance-Prop.Liab.Malpractice			173,782	173,782		173,782	17,693	191,475		26
27	Other (specify):*							22,756	22,756		27
28	TOTAL General Administration	203,290	29,578	1,526,858	1,759,726	24,415	1,784,141	(486,239)	1,297,902		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,090,544	593,595	2,194,168	5,878,307	(5,150)	5,873,157	(555,918)	5,317,239		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr #0037960 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			56,210	56,210		56,210	372,626	428,836			30
31	Amortization of Pre-Op. & Org.							54,165	54,165			31
32	Interest			50,412	50,412		50,412	704,816	755,228			32
33	Real Estate Taxes			(38,279)	(38,279)	5,150	(33,129)	197,022	163,893			33
34	Rent-Facility & Grounds			968,869	968,869		968,869	(968,869)				34
35	Rent-Equipment & Vehicles			12,040	12,040		12,040	7,060	19,100			35
36	Other (specify):*							36,799	36,799			36
37	TOTAL Ownership			1,049,252	1,049,252	5,150	1,054,402	403,619	1,458,021			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		109,935	200,644	310,579		310,579		310,579			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,260	118,260		118,260		118,260			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		109,935	318,904	428,839		428,839		428,839			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,090,544	703,530	3,562,324	7,356,398		7,356,398	(152,299)	7,204,099			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsgr Rehab Ctr

0037960

Report Period Beginning: 01/01/03

Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(234,255)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(88)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,050)	20		18
19	Entertainment				19
20	Contributions	(410)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(61,939)	21		24
25	Fund Raising, Advertising and Promotional	(3,029)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,343)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,873)	20		28
29	Other-Attach Schedule	(40,147)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (358,133)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	205,835		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 205,835		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (152,299)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
Columbus Park Nsg Rehab Ctr			
0007968			
Report Period Beginning:	01/01/03		
Ending:	12/31/03		
NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1 Drugs - V/A	\$ (649)	10	1
2 Fees - Building Partnership	(445)	20	2
3 Jury Duty	(86)	10	3
4 Tower Rent	(11,051)	32	4
5 Non-allowable legal fees	(12,763)	49	5
6 COPI Dues	(2,624)	20	6
7 Capitalized R&M	(12,091)	06	7
8 out of period seminar	(500)	24	8
9			9
10			10
11			11
12			12
13			13
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100			100
101 Total	(40,147)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Columbus Park Nrsng Rehab Ctr

0037960

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(19,934)							(19,934)	1
2	Food Purchase	(88)											(88)	2
3	Housekeeping			707				(65)					642	3
4	Laundry													4
5	Heat and Other Utilities			912	1,462								2,374	5
6	Maintenance	(12,091)		720	(12,483)	(12,844)							(36,698)	6
7	Other (specify):*				1,090	9,319							10,409	7
8	TOTAL General Services	(12,179)		2,339	(9,931)	(23,459)		(65)					(43,295)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(735)			(20,177)			(8,434)					(29,346)	10
10a	Therapy					(2,631)							(2,631)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				4,807	786							5,593	15
16	TOTAL Health Care and Programs	(735)			(15,370)	(1,845)		(8,434)					(26,384)	16
	C. General Administration													
17	Administrative			17,525	(66,113)	(332,585)							(381,173)	17
18	Directors Fees													18
19	Professional Services	(12,701)	1,200	(103,673)	(17,232)	10,030							(122,376)	19
20	Fees, Subscriptions & Promotions	(16,431)	445	203	87								(15,696)	20
21	Clerical & General Office Expenses	(70,282)		57,888	2,112								(10,282)	21
22	Employee Benefits & Payroll Taxes						(319)						(319)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(500)		171	361								32	24
25	Other Admin. Staff Transportation			795	2,331								3,126	25
26	Insurance-Prop.Liab.Malpractice		16,444	402	847								17,693	26
27	Other (specify):*			10,301	3,620	8,835							22,756	27
28	TOTAL General Administration	(99,914)	18,089	(16,388)	(73,987)	(313,720)	(319)						(486,239)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(112,827)	18,089	(14,049)	(99,288)	(339,024)	(319)	(8,499)					(555,918)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Columbus Park Nrsgr Rehab Ctr # 0037960 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(234,255)	601,014	2,540	3,327								372,626	30
31	Amortization of Pre-Op. & Org.		54,165										54,165	31
32	Interest	(11,051)	712,235	692	2,940								704,816	32
33	Real Estate Taxes		190,295	2,338	4,389								197,022	33
34	Rent-Facility & Grounds		(968,869)										(968,869)	34
35	Rent-Equipment & Vehicles			2,290	4,770								7,060	35
36	Other (specify):*		36,799										36,799	36
37	TOTAL Ownership	(245,306)	625,639	7,860	15,426								403,619	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(358,133)	643,728	(6,189)	(83,862)	(339,024)	(319)	(8,499)					(152,299)	45

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr# 0037960

Report Period Beginning:

01/01/03Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rental Income	\$ 968,869	Columbus Park LLC	100.00%	\$	(968,869)
2	V	33 Prior Year Real Estate Tax adj		Columbus Park LLC	100.00%	38,279	38,279
3	V	20 Fees		Columbus Park LLC	100.00%	445	445
4	V	26 Insurance - Property		Columbus Park LLC	100.00%	16,444	16,444
5	V	32 Interest		Columbus Park LLC	100.00%	728,646	728,646
6	V	19 Professional Fees		Columbus Park LLC	100.00%	1,200	1,200
7	V	33 Real Estate Tax Expense		Columbus Park LLC	100.00%	154,700	154,700
8	V	32 Interest Income	16,411	Columbus Park LLC	100.00%		(16,411)
9	V	31 Amortization Expense		Columbus Park LLC	100.00%	54,165	54,165
10	V	30 Depreciation		Columbus Park LLC	100.00%	601,014	601,014
11	V	33 P/Y Real Estate Tax	2,684	Columbus Park LLC	100.00%		(2,684)
12	V	36 Insurance - MIP		Columbus Park LLC	100.00%	36,799	36,799
13	V						
14	Total		\$ 987,964			\$ 1,631,692	\$ * 643,728

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr

0037960

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 707	\$ 707 15
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	912	912 16
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	720	720 17
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	17,525	17,525 18
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	2,237	2,237 19
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	203	203 20
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	57,888	57,888 21
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	171	171 22
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	795	795 23
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	402	402 24
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	10,301	10,301 25
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	2,540	2,540 26
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	692	692 27
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,338	2,338 28
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,290	2,290 29
30	V						30
31	V						31
32	V	19 ACCOUNT./BOOKKEEPING	105,910	PREFERRED BOOKKEEPING	100.00%		(105,910) 32
33	V	19 COMPUTER	5,184	PREFERRED BOOKKEEPING	100.00%	5,184	33
34	V						34
35	V						35
36	V						36
37	V						37
38	V						38
39	Total		\$ 111,094			\$ 104,905	\$ * (6,189) 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr

0037960

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 1,462	\$ 1,462	15
16	V	6 REPAIRS AND MAINT.	19,440	S.I.R. MANAGEMENT, INC.	100.00%	6,957	(12,483)	16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,090	1,090	17
18	V	10 NURSING	42,768	S.I.R. MANAGEMENT, INC.	100.00%	22,591	(20,177)	18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	4,807	4,807	19
20	V	17 ADMINISTRATIVE	75,816	S.I.R. MANAGEMENT, INC.	100.00%	9,703	(66,113)	20
21	V	19 PROFESSIONAL FEES	17,496	S.I.R. MANAGEMENT, INC.	100.00%	264	(17,232)	21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	87	87	22
23	V	21 CLERICAL & GENERAL	22,032	S.I.R. MANAGEMENT, INC.	100.00%	24,144	2,112	23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	361	361	24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,331	2,331	25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	847	847	26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	3,620	3,620	27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	3,327	3,327	28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	2,940	2,940	29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	4,389	4,389	30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	4,770	4,770	31
32	V							32
33	V	35 LEASED EQUIPMENT		S.I.R. MANAGEMENT, INC.	100.00%			33
34	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%			34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 177,552			\$ 93,690	\$ * (83,862)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr

0037960

Report Period Beginning: 01/01/03

Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 DIETARY SALARIES	\$ 22,032	S.I.R. MANAGEMENT, INC.	100.00%	\$ 7,125	\$ (14,907)
16	V	7 EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,516	1,516
17	V	17 ADMIN./LEGAL SALARIES	386,991	S.I.R. MANAGEMENT, INC.	100.00%	58,726	(328,265)
18	V	19 FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	15,214	15,214
19	V	27 EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	8,835	8,835
20	V						
21	V	17 ADMIN. SALARY		S.I.R. MANAGEMENT, INC.	100.00%		
22	V	27 EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%		
23	V						
24	V	17 ADMIN SALARY		S.I.R. MANAGEMENT, INC.	100.00%		
25	V	27 EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%		
26	V						
27	V	10A SPECIAL REHAB	6,324	S.I.R. MANAGEMENT, INC.	100.00%	3,693	(2,631)
28	V	15 EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	786	786
29	V						
30	V	6 REPAIRS AND MAINT.	40,716	S.I.R. MANAGEMENT, INC.	100.00%	27,872	(12,844)
31	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	5,929	5,929
32	V						
33	V	1 DIETICIAN SALARIES	13,800	S.I.R. MANAGEMENT, INC.	100.00%	8,773	(5,027)
34	V	7 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,874	1,874
35	V						
36	V	19 LEGAL FEES	5,184	S.I.R. MANAGEMENT, INC.	100.00%		(5,184)
37	V						
38	V	17 COUNCIL DUES	4,320	S.I.R. MANAGEMENT, INC.	100.00%		(4,320)
39	Total		\$ 479,367			\$ 140,343	\$ * (339,024)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr# 0037960Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 75,675	\$ 75,675	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	75,995	CCS EMPLOYEE BENEFIT GROUP	100.00%		(75,995)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 75,995			\$ 75,675	\$ * (319)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr# 0037960Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 DIETARY	\$	XCEL MEDICAL SUPPLY, LLC	100.00%	\$	\$
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%		
17	V	03 HOUSEKEEPING	494	XCEL MEDICAL SUPPLY, LLC	100.00%	429	(65)
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%		
19	V	06 REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%		
20	V	10 NURSING	64,074	XCEL MEDICAL SUPPLY, LLC	100.00%	55,640	(8,434)
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%		
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%		
24	V	22 EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%		
25	V	39 ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%		
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 64,568			\$ 56,069	\$ * (8,499)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr# 0037960Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr# 0037960Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr# 0037960Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr# 0037960Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Columbus Park Nrsng Rehab Ctr # 0037960 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Nenita Guzman	Shareholder	Dietary	1.89%	See Attached	5.62	11.24%	SIR Salary	\$ 7,125	01-07	1
2	Louise Bergthold	Shareholder	Administrative	9.00%	See Attached	6.18	11.24%	SIR Salary	20,018	17-07	2
3	Tom Winter	Shareholder	Administrative	0.94%	See Attached	6.79	11.32%	Pref Bkp sal	17,525	17-07	3
4	Eric Rothner	Shareholder	Administrative	3.77%	See Attached	0.62	1.13%	SIR Salary	16,202	17-07	4
5	Adam Vales	Relative	Clerical	0.00%	See Attached	0.39	0.98%	CCS-Salary	303	22-03	5
6	Leo Feigenbaum	Shareholder	Administrative	6.60%	See Attached	1.00	1.59%	Mgmt Fee	36,000	17-03	6
7	Noah Wolff	Shareholder	Administrative	4.25%	See Attached			Mgmt Fee	36,000	17-03	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 133,173		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsng Rehab Ctr # 0037960 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsgr Rehab Ctr# 0037960

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization PREFERRED BOOKKEEPING SERVICES
 Street Address 4100 WEST PRATT AVE.
 City / State / Zip Code LINCOLNWOOD, IL. 60712
 Phone Number (847) 674-5200
 Fax Number (847) 674-5267

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	935,658	11	\$ 6,250	\$ 105,910	\$ 707	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	935,658	11	8,058	105,910	912	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	935,658	11	6,361	105,910	720	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	935,658	11	154,828	105,910	17,525	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	935,658	11	19,761	105,910	2,237	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	935,658	11	1,793	105,910	203	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	935,658	11	511,408	105,910	57,888	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	935,658	11	1,508	105,910	171	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	935,658	11	7,028	105,910	795	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	935,658	11	3,553	105,910	402	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	935,658	11	91,005	105,910	10,301	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	935,658	11	22,443	105,910	2,540	12
13	32	INTEREST	BOOK./ACCNT.INCOME	935,658	11	6,117	105,910	692	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	935,658	11	20,656	105,910	2,338	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	935,658	11	20,229	105,910	2,290	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					5,184	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 880,998	\$ 608,675	\$ 104,905	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsrg Rehab Ctr# 0037960

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.Street Address 6840 N. LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 675 -7979Fax Number (847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	PATIENT DAYS	641,706	10	\$ 13,016	\$	72,064	\$ 1,462	1
2	6 REPAIRS AND MAINT.	PATIENT DAYS	641,706	10	61,951		45,622	72,064	2
3	7 EMP. BEN.-GEN. SERV.	PATIENT DAYS	641,706	10	9,705		72,064	1,090	3
4	10 NURSING	PATIENT DAYS	641,706	10	201,162		201,162	72,064	4
5	15 EMP. BEN.-H.C.	PATIENT DAYS	641,706	10	42,801		72,064	4,807	5
6	17 ADMINISTRATIVE	PATIENT DAYS	641,706	10	86,401		86,401	72,064	6
7	19 PROFESSIONAL FEES	PATIENT DAYS	641,706	10	2,349		72,064	264	7
8	20 FEES,SUBSCRIPTIONS	PATIENT DAYS	641,706	10	773		72,064	87	8
9	21 CLERICAL & GENERAL	PATIENT DAYS	641,706	10	214,995		167,138	72,064	9
10	24 EDUCATION & SEMINAR	PATIENT DAYS	641,706	10	3,219		72,064	361	10
11	25 OTHER ADMIN. STAFF TRANS	PATIENT DAYS	641,706	10	20,755		72,064	2,331	11
12	26 INSURANCE	PATIENT DAYS	641,706	10	7,541		72,064	847	12
13	27 EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	641,706	10	32,233		72,064	3,620	13
14	30 DEPRECIATION	PATIENT DAYS	641,706	10	29,623		72,064	3,327	14
15	32 INTEREST	PATIENT DAYS	641,706	10	26,178		72,064	2,940	15
16	33 REAL ESTATE TAXES	PATIENT DAYS	641,706	10	39,087		72,064	4,389	16
17	35 EQUIPMENT RENTAL	PATIENT DAYS	641,706	10	42,473		72,064	4,770	17
18									18
19	35 LEASED EQUIPMENT	LEASING INCOME	24,090	1					19
20	30 DEPRECIATION	LEASING INCOME	24,090	1	91,098				20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 925,360	\$ 500,323		\$ 93,690	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsgr Rehab Ctr# 0037960

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.Street Address 6840 N. LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 675 -7979Fax Number (847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	DIETARY SALARIES	PATIENT DAYS	641,706	10	\$ 63,448	\$ 63,448	72,064	\$ 7,125	1
2	EMP. BEN.-DIETARY	PATIENT DAYS	641,706	10	13,496		72,064	1,516	2
3	ADMIN./LEGAL SALARIES	PATIENT DAYS	641,706	10	522,936	522,936	72,064	58,726	3
4	FINANCIAL CONSULTANT	PATIENT DAYS	641,706	10	135,472		72,064	15,214	4
5	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	641,706	10	\$ 78,674	\$	72,064	\$ 8,835	5
6									6
7	17 ADMIN. SALARY	AVG HRS WKD	30	5	170,502	170,502			7
8	27 EMP. BEN.-ADMIN.	AVG HRS WKD	30	5	28,886				8
9					\$	\$		\$	9
10	17 ADMIN SALARY	AVG HRS WKD	30	5	151,372	151,372			10
11	27 EMP. BEN.-ADMIN.	AVG HRS WKD	30	5	28,244				11
12									12
13	10A SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 62,910	\$ 62,910	6,324	\$ 3,693	13
14	15 EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	107,736	7	13,382		6,324	786	14
15									15
16	6 REPAIRS AND MAINT.	MAINTENANCE INC.	163,332	10	111,809	111,809	40,716	27,872	16
17	7 EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	163,332	10	23,783		40,716	5,929	17
18									18
19	1 DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	79,717	79,717	13,800	8,773	19
20	7 EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	17,031		13,800	1,874	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,501,663	\$ 1,162,695		\$ 140,343	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsgr Rehab Ctr # 0037960 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
 Street Address 4101 W. MAIN ST.
 City / State / Zip Code SKOKIE, IL 60076
 Phone Number (847)905-4000
 Fax Number (847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 75,675	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 75,675	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsgr Rehab Ctr # 0037960 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization XCEL MEDICAL SUPPLY, LLC
 Street Address 2201 MAIN STREET
 City / State / Zip Code EVANSTON, IL 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation		\$	\$			1
2	02	FOOD	Direct Allocation						2
3	03	HOUSEKEEPING	Direct Allocation					429	3
4	04	LAUNDRY	Direct Allocation						4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						5
6	10	NURSING	Direct Allocation					55,640	6
7	10A	THERAPY	Direct Allocation						7
8	12	SOCIAL SERVICE	Direct Allocation						8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation						9
10	22	EMPLOYEE BENEFITS	Direct Allocation						10
11	39	ANCILLARY	Direct Allocation						11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 56,069	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsng Rehab Ctr # 0037960 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsng Rehab Ctr # 0037960 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsng Rehab Ctr # 0037960 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsng Rehab Ctr # 0037960 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Mortgage		X				\$	\$ 0			\$ 529,200	1
2	HUD		X	Mortgage	\$88,228.00	9/9/03	11,316,100	11,292,053	9/9/33	5.67%	199,446	2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	CIB Bank		X	Working Capital				1,065,000			50,412	6
7	Allocation from Preferred		X								692	7
8	See Supplemental Schedule										(8,111)	8
9	TOTAL Facility Related				\$88,228.00		\$ 11,316,100	\$ 12,357,053			\$ 771,639	9
	B. Non-Facility Related*											
10												10
11	Interest Income - Bldg Prtnshp		X								(16,411)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						\$	\$			\$ (16,411)	14
15	TOTALS (line 9+line14)						\$ 11,316,100	\$ 12,357,053			\$ 755,228	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 36,799 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
 (See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
 (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Allocation from SIR Mgmt		X				\$	\$			\$	2,940	8
9	Tower Rent		X									(11,051)	9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital											(8,111)	14
	B. Non-Facility Related*												
15							\$	\$			\$		15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Columbus Park Nrsgr Rehab Ctr**# **0037960**

Report Period Beginning:

01/01/03

Ending:

12/31/03**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.	\$	153,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	157,643	2
3. Under or (over) accrual (line 2 minus line 1).	\$	4,043	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	154,700	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	5,150	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	163,893	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998	154,334	8
	1999	153,298	9
	2000	148,057	10
	2001	149,243	11
	2002	150,916	12
2003 accrual = 2002 actual X 2.5% = 150,916 X 2.5% = 154700 (rounded)			
Preferred Allocation = 2054; SIR Management Allocation: 3857			
In 5 adj. Includes \$150 expense from related companies			
		FOR OHF USE ONLY	
	13	FROM R. E. TAX STATEMENT FOR 2002 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Columbus Park Nrsng Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037960

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-17-401-026-0000</u>	<u>Long Term Care Property</u>	\$ <u>87,924.72</u>	\$ <u>87,924.72</u>
2. <u>16-17-401-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>43,738.70</u>	\$ <u>43,738.70</u>
3. <u>16-17-401-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>19,252.54</u>	\$ <u>19,252.54</u>
4. <u>See Attached</u>	<u>Preferred Bookkeeping Allocation</u>	\$ <u>18,148.53</u>	\$ <u>2,054.00</u>
5. <u>See Attached</u>	<u>SIR Management Allocation</u>	\$ <u>34,343.00</u>	\$ <u>3,857.00</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>203,407.49</u></u>	\$ <u><u>156,826.96</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? XX YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Columbus Park Nrsng Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037960

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A.
 Square Feet:
 29,685

B. General Construction Type:
 Exterior
 Brick
 Frame
 Number of Stories
 6

C.
 Does the Operating Entity?
 (a) Own the Facility
 (X) (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
 Does the Operating Entity?
 (X) (a) Own the Equipment
 (X) (b) Rent equipment from a Related Organization.
 (X) (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
 List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F.
 Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 NO

If so, please complete the following:

1. Total Amount Incurred:
 211,742

2. Number of Years Over Which it is Being Amortized:
 3 and 30

3. Current Period Amortization:
 54,165

4. Dates Incurred:
 4/11/02 and 9/9/03

Nature of Costs:
 Closing, Engineering and Environmental; and HUD mortgage
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			2002	\$ 300,000	1
2					2
3	TOTALS			\$ 300,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr

0037960

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1992		51,845		20	2,592	2,592	29,724	9
10	Various		1993		71,558		20	3,579	3,579	39,371	10
11	Various		1994		46,784		20	2,339	2,339	22,760	11
12	Various		1995		131,277		20	6,662	(6,662)	57,184	12
13	Various		1996		62,128		20	3,108	3,108	24,239	13
14	Various		1997		40,477		20	2,025	2,025	13,311	14
15	Various		1998		419,667		20	20,987	20,987	113,906	15
16	Various		1999		244,069		20	12,197	12,197	55,446	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

	1	2	3	4	5	6	7	8	9	
	Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37				\$	\$		\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
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54										54
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57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)			7,013,521	183,382		200,386	17,004	400,772	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)			92,730	3,168		3,522	354	30,749	68
69	Financial Statement Depreciation				33,388			(33,388)		69
70	TOTAL (lines 4 thru 69)			\$ 8,174,056	\$ 219,938		\$ 257,397	\$ 24,135	\$ 787,462	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,174,056	\$ 219,938		\$ 257,397	\$ 37,459	\$ 787,462	1
2	Chute Doors	2000	2,887		20	144	144	565	2
3	Flooring	2000	5,190		20	260	260	1,039	3
4	Flooring	2000	2,786		20	139	139	557	4
5	Boiler Work	2000	7,842		20	392	392	1,274	5
6	Boiler Work	2000	1,605		20	80	80	294	6
7	Glass & Door	2000	1,525		20	76	76	229	7
8	Paint	2000	1,095		20	55	55	165	8
9	Paint	2000	635		20	32	32	96	9
10	Hvac	2000	1,366		20	68	68	205	10
11	Hvac	2000	1,112		20	56	56	167	11
12	Screens	2000	1,375		20	69	69	207	12
13	Boiler Work	2001	4,903		20	245	245	674	13
14	Water Tank	2001	2,375		20	119	119	317	14
15	Paving	2001	3,700		20	185	185	432	15
16	Roofing	2001	4,520		20	226	226	527	16
17	Linen/Storage	2001	61,335		20	3,067	3,067	6,390	17
18	Paint	2001	3,683		20	184	184	521	18
19	Window	2001	830		20	42	42	122	19
20	Sink	2001	866		20	43	43	126	20
21	Flooring	2001	1,093		20	55	55	155	21
22	Wallcover	2001	534		20	27	27	76	22
23	Door-Panic Device	2001	553		20	28	28	60	23
24	Hot Water Tank	2001	1,378		20	69	69	207	24
25	Hot Water Tank	2001	2,140		20	107	107	276	25
26	Hvac Work	2002	3,721		20	372	372	744	26
27	Hvac Work	2002	8,830		20	883	883	1,177	27
28	Freezer Door	2002	2,445		20	245	245	306	28
29	Dampers	2002	13,700		20	1,370	1,370	1,598	29
30	Refrigerator	2002	5,328		20	533	533	1,021	30
31	Painting	2002	1,821		20	182	182	334	31
32	Nurses Station Lights	2002	1,071		20	107	107	187	32
33	Water Heater	2002	2,108		20	176	176	220	33
34	TOTAL (lines 1 thru 33)		\$ 8,328,408	\$ 219,938		\$ 267,033	\$ 47,095	\$ 807,730	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 8,328,408	\$ 219,938		\$ 267,033	\$ 47,095	\$ 807,730	1
2	Various Painting	2002	1,815		20	182	182	333	2
3	Window Screen	2003	782		20	52	52	26	3
4	Carpeting	2003	7,014		20	205	205	205	4
5	Hvac Work	2003	7,247		20	423	423	423	5
6	Water Heater	2003	4,840		20	222	222	222	6
7	Vent Covers	2003	6,700		20	168	168	168	7
8	Window Coverings	2003	9,429		20	236	236	236	8
9	Elevator Work	2003	67,488		20	281	281	281	9
10	Stairwell Alarm 1/2 Pd	2003	1,535		20	38	38	38	10
11	Compressor	2003	1,411		20	12	12	12	11
12	Fire Pump Work	2003	16,575		20	207	207	207	12
13	Smoke Detector	2003	3,225		20	13	13	13	13
14	Electrical Work	2003	11,026		20	46	46	46	14
15	Outside Lights	2003	1,060		20	4	4	4	15
16	Electrical Cable	2003	9,551		20	40	40	40	16
17	Water Pump	2003	2,305		20	10	10	10	17
18	Sprinkler Svstem	2003	1,806		20	8	8	8	18
19	Middle Style Door	2003	1,453		20	73	73	73	19
20	Door Screens & Clips	2003	1,975		20	66	66	66	20
21	Block Heater & Hardware	2003	1,037		20	35	35	35	21
22	Replace Faucet	2003	1,175		20	20	20	20	22
23	Repair Elevator Doors	2003	1,010		20	46	46	46	23
24	Elevator Jack Packing	2003	2,184		20	46	46	46	24
25	Sprinkler System Repair	2003	2,355		20	29	29	29	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
19									19
20									20
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,493,406	\$ 219,938		\$ 269,495	\$ 49,557	\$ 810,317	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	216		2002		\$ 7,013,521	\$ 183,382		\$ 200,386	\$ 17,004	\$ 400,772	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,013,521	\$ 183,382		\$ 200,386	\$ 17,004	\$ 400,772	70

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr

0037960

Report Period Beginning:

01/01/03

Ending:

12/31/03

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Bed*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4		1993	1993	\$ 30,008	\$ 953	35	\$ 722	\$ (231)	\$ 9,002
5		1993	1993	15,983	507	35	457	(50)	4,795
6									
7									
8									
Improvement Type**									
9	Allocation from Preferred Bookkeeping	1997		19,961	447	20	998	551	6,796
10	Allocation from Preferred Bookkeeping	1999		158	-	20	8	8	36
11	Allocation from Preferred Bookkeeping	2000		1,001	-	20	50	50	171
12									
13	Allocation from SIR Properties - SIR Management	2002		119	-	20	6	6	9
14	Allocation from SIR Properties - SIR Management	1999		3,802	380	20	190	(190)	856
15	Allocation from SIR Properties - SIR Management	1998		1,817	182	20	91	(91)	50
16	Allocation from SIR Properties - SIR Management	1997		113	11	20	6	(5)	42
17	Allocation from SIR Properties - SIR Management	1994		286	7	20	14	7	136
18	Allocation from SIR Properties - SIR Management	1993		487	8	20	24	16	256
19									
20	Allocation from SIR Properties - Preferred Bookkeeping	2002		63	-	20	3	3	5
21	Allocation from SIR Properties - Preferred Bookkeeping	1999		2,025	203	20	101	(102)	456
22	Allocation from SIR Properties - Preferred Bookkeeping	1998		968	97	20	48	(49)	266
23	Allocation from SIR Properties - Preferred Bookkeeping	1997		60	6	20	3	(3)	23
24	Allocation from SIR Properties - Preferred Bookkeeping	1994		152	4	20	8	4	72
25	Allocation from SIR Properties - Preferred Bookkeeping	1993		259	4	20	13	9	136
26									
27	Allocation from SIR Management	1993		12,888	359	20	649	290	7,029
28	Allocation from SIR Management	1994		40	-	20	4	4	38
29	Allocation from SIR Management	1995		295	-	20	15	15	124
30	Allocation from SIR Management	1999		1,400	-	20	70	70	295
31	Allocation from SIR Management	2000		845	-	20	42	42	156
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$ 92,730	\$ 3,168		\$ 3,522	\$ 354	\$ 30,749		70

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,641,057	\$ 440,970	\$ 158,685	\$ (282,285)	10	\$ 484,606	71
72	Current Year Purchases	14,763	2,183	656	(1,527)	10	656	72
73	Fully Depreciated Assets	55,327				10	55,327	73
74								74
75	TOTALS	\$ 1,711,147	\$ 443,153	\$ 159,341	\$ (283,812)		\$ 540,589	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 10,504,553	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 663,091	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 428,836	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (234,255)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,350,906	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 12,311 Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Van	\$ 553.85	\$ 6,789	17
18					18
19					19
20					20
21	TOTAL		\$ 553.85	\$ 6,789	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	39 - 03	hrs	\$		
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			34,591				34,591	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 03	hrs			78,904				78,904	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 02	# of prescrpts				58,626			58,626	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program	39 - 03				926	20,268			21,194	12
13	Other (specify): See Supplemental					245	31,041			31,286	13
14	TOTAL			\$		\$ 200,644	\$ 109,935		\$	310,579	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 61,969	\$ 74,895	1
2	Cash-Patient Deposits	58,329	58,329	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,515,367	1,515,367	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,019	27,019	6
7	Other Prepaid Expenses	1,578	95,073	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		303,561	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,664,262	\$ 2,074,244	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		300,000	13
14	Buildings, at Historical Cost		7,013,521	14
15	Leasehold Improvements, at Historical Cost	1,028,079	1,028,079	15
16	Equipment, at Historical Cost	553,042	1,879,521	16
17	Accumulated Depreciation (book methods)	(615,263)	(1,605,578)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		136,770	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 965,858	\$ 8,752,313	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,630,120	\$ 10,826,557	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 293,157	\$ 293,158	26
27	Officer's Accounts Payable	13,195	13,195	27
28	Accounts Payable-Patient Deposits	61,732	61,732	28
29	Short-Term Notes Payable	1,065,000	1,065,000	29
30	Accrued Salaries Payable	221,764	221,764	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,599	20,599	31
32	Accrued Real Estate Taxes(Sch.IX-B)		154,700	32
33	Accrued Interest Payable	1,488	54,843	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	19,300	19,300	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,021	1,021	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,697,256	\$ 1,905,312	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,292,053	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 11,292,053	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,697,256	\$ 13,197,365	46
47	TOTAL EQUITY (page 18, line 24)	\$ 932,864	\$ (2,370,808)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,630,120	\$ 10,826,557	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 938,455	1
2	Restatements (describe):		2
3	<u>rounding error</u>	7	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 938,462	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	418,402	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(424,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (5,598)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 932,864	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,123,468	1
2	Discounts and Allowances for all Levels	(83,592)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,039,876	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	610,750	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 610,750	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	54,816	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,193	19
20	Radiology and X-Ray	2,030	20
21	Other Medical Services	52,998	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 113,037	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	11,137	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,137	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,774,800	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,372,861	31
32	Health Care	2,745,720	32
33	General Administration	1,759,726	33
	B. Capital Expense		
34	Ownership	1,049,252	34
	C. Ancillary Expense		
35	Special Cost Centers	310,579	35
36	Provider Participation Fee	118,260	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,356,398	40
41	Income before Income Taxes (line 30 minus line 40)**	418,402	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 418,402	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? cash basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr# 0037960Report Period Beginning: 01/01/03Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,751	1,872	\$ 61,745	\$ 32.98	1
2	Assistant Director of Nursing	2,256	2,389	66,531	27.85	2
3	Registered Nurses	13,519	14,519	318,817	21.96	3
4	Licensed Practical Nurses	28,305	30,619	576,754	18.84	4
5	Nurse Aides & Orderlies	102,878	109,127	954,304	8.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,667	13,475	117,502	8.72	8
9	Activity Director	1,989	2,086	25,471	12.21	9
10	Activity Assistants	10,681	11,304	72,386	6.40	10
11	Social Service Workers	7,285	7,890	92,100	11.67	11
12	Dietician					12
13	Food Service Supervisor	1,902	2,086	34,332	16.46	13
14	Head Cook	5,173	5,830	54,374	9.33	14
15	Cook Helpers/Assistants	17,821	19,167	144,804	7.55	15
16	Dishwashers					16
17	Maintenance Workers	3,856	4,157	41,177	9.91	17
18	Housekeepers	20,983	22,396	167,784	7.49	18
19	Laundry	10,553	11,389	85,798	7.53	19
20	Administrator	1,973	2,086	73,271	35.13	20
21	Assistant Administrator	2,029	2,079	37,589	18.08	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,318	8,954	92,430	10.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,906	4,292	73,375	17.10	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	257,845	275,717	\$ 3,090,544 *	\$ 11.21	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	\$ 13,800	01-03	35
36	Medical Director	monthly	7,200	09-03	36
37	Medical Records Consultant	monthly	4,128	10-03	37
38	Nurse Consultant	monthly	42,768	10-03	38
39	Pharmacist Consultant	monthly	1,931	10-03	39
40	Physical Therapy Consultant	179	9,680	10a-03	40
41	Occupational Therapy Consultant	162	8,763	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	54	3,016	10a-03	43
44	Activity Consultant	75	3,557	11-03	44
45	Social Service Consultant	30	1,873	12-03	45
46	Other(specify)				46
47	<u>Director of Food Services</u>	monthly	22,032	01-03	47
48	<u>Specialized Services</u>	monthly	6,324	12-03	48
49	TOTAL (lines 35 - 48)	500	\$ 125,072		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	96	\$ 4,472	10-03	50
51	Licensed Practical Nurses	5,021	192,460	10-03	51
52	Nurse Aides	16	311	10-03	52
53	TOTAL (lines 50 - 52)	5,133	\$ 197,243		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsng Rehab Ctr

0037960

Report Period Beginning: 01/01/03

Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lee Martin	administrator	0	73,271	Workers' Compensation Insurance	66,247	IDPH License Fee		
Lisa Jackson	asst. admin.	0	37,589	Unemployment Compensation Insurance	30,777	Advertising: Employee Recruitment	9,610	
				FICA Taxes	233,836	Health Care Worker Background Check	973	
				Employee Health Insurance	135,106	(Indicate # of checks performed <u>139</u>)		
				Employee Meals	29,565	Advertising & Promotion	3,029	
				Illinois Municipal Retirement Fund (IMRF)*		Inspections and Permits	2,472	
				Chicago Head Tax	7,632	Dues	7,257	
				Employee Benefits - 401K Matching	2,894	Licenses	963	
				Other Employee Benefits	8,533	Yellow page ads	6,873	
						See Supplemental Schedule	290	
						Less: Public Relations Expense ()		
						Non-allowable advertising	(3,029)	
						Yellow page advertising	(6,873)	
TOTAL (agree to Schedule V, line 17, col. 1)						TOTAL (agree to Sch. V, line 20, col. 8)	21,565	
(List each licensed administrator separately.)			110,860					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				
Description			Amount					
Management Fees - SIR Management			386,991					
See Supplemental Schedule			152,136					
TOTAL (agree to Schedule V, line 17, col. 3)			539,127					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Stu Sikes	Legal		200				Out-of-State Travel	
Scott Forrest Stern & Assoc	Legal		165					
Winston & Strawn	Legal		1,160				In-State Travel	
Michael Best & Friedrich	Legal		6,789					
Stone & McGuire	Legal		4,630					
Foley & Lardner	Legal		6,694					
Frost, Ruttenberg & Rothblatt	Accounting		13,815				Seminar Expense	3,902
Preferred Bookkeeping	Accounting		28,150				Allocation from Preferred Bkpg	171
LTC Solutions	Computer Support		1,320				Allocation from SIR Mgmt	361
ICS Solutions	Computer Support		165					
Personnel Planners	Unemployment Consulting		2,440				Entertainment Expense ()	
See Supplemental Schedule			112,174				(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL				4,434
(If total legal fees exceed \$2500 attach copy of invoices.)			177,702					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	none		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Columbus Park Nrsg Rehab Ctr

STATE OF ILLINOIS

0037960

Report Period Beginning:

01/01/03

Ending:

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12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on LTC: 9881
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 20,410 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 118,260
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 29,565 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% of ln 14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NA If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.